

§ 457.955

§ 457.955 Conditions necessary to contract as a managed care entity (MCE).

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) The State must ensure that the arrangements or procedures required in paragraph (a) of this section—

(1) Enforce MCE compliance with all applicable Federal and State standards;

(2) Prohibit MCEs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity; and

(3) Include a mechanism for the MCE to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

§ 457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect the enrollee's eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and

(b) Promptly redetermine eligibility when the State has information about these changes.

§ 457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for CHIP.

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§ 457.980 Verification of enrollment and provider services received.

The State must establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

[66 FR 2685, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 457.985 Integrity of professional advice to enrollees.

The State must ensure through its contracts for coverage and services that its contractors comply with—

(a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and

(b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

§ 457.990 Provider and supplier screening, oversight, and reporting requirements.

The following provisions and their corresponding regulations apply to a State under title XXI of the Act, in the same manner as these provisions and regulations apply to a State under title XIX of the Act:

(a) Part 455, Subpart E, of this chapter.

(b) Sections 1902(a)(77) and 1902(kk) of the Act pertaining to provider and supplier screening, oversight, and reporting requirements.

[76 FR 5970, Feb. 2, 2011]

Subpart J—Allowable Waivers: General Provisions

SOURCE: 66 FR 2686, Jan. 11, 2001, unless otherwise noted.

§ 457.1000 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements to permit a State to exceed the 10 percent cost limit on expenditures other than benefit expenditures; and

(2) Section 2105(c)(3) of the Act, which permits the purchase of family coverage.

(b) *Scope.* This subpart sets forth requirements for obtaining a waiver under title XXI.

(c) *Applicability.* This subpart applies to separate child health programs; and applies to Medicaid expansion programs when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

[66 FR 2686, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§457.1003 CMS review of waiver requests.

CMS will review the waiver requests under this subpart using the same time frames used for State plan amendments, as specified in §457.160.

§457.1005 Cost-effective coverage through a community-based health delivery system.

(a) *Availability of waiver.* The Secretary may waive the requirements of §457.618 (the 10 percent limit on expenditures not used for health benefits coverage for targeted low-income children, that meets the requirements of §457.410) in order to provide child health assistance to targeted low-income children under the State plan through a cost-effective, community-based health care delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or section 1923 of the Act.

(b) *Requirements for obtaining a waiver.* To obtain a waiver for cost-effective coverage through a community-based health delivery system, a State must demonstrate that—

(1) The coverage meets all of the requirements of this part, including subpart D and subpart E.

(2) The cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan.

(c) *Three-year approval period.* An approved waiver remains in effect for no more than 3 years.

(d) *Application of cost savings.* If the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the difference in the cost of coverage for each child enrolled in a community-based health delivery system for—

(1) Other child health assistance, health services initiatives, or outreach; or

(2) Any reasonable costs necessary to administer the State's program.

§457.1010 Purchase of family coverage.

A State may purchase family coverage that includes coverage for targeted low-income children if the State establishes that—

(a) Purchase of family coverage is cost-effective under the standards described in §457.1015;

(b) The State does not purchase the coverage if it would otherwise substitute for health insurance coverage that would be provided to targeted, low-income children but for the purchase of family coverage; and

(c) The coverage for the family otherwise meets the requirements of this part.

§457.1015 Cost-effectiveness.

(a) *Definition.* For purposes of this subpart, “cost-effective” means that the State's cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the State plan only for the eligible targeted low-income children involved.

(b) *Cost comparisons.* A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of coverage only for the targeted low-income children under the